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	295045	A. BUILDING _____ B. WING _____	05/22/2009

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 22489 This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility on 5/19/09 through 5/22/09, in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities. The census was 74 residents. The sample size was 15 sampled residents which included 2 closed records. There was 1 unsampled resident. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000		
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 22489 Based on observation and interview, the facility failed to properly investigate and report when a resident complained of improper patient care from a staff (#9). Findings include:	F 226		6/17/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 226	Continued From page 1 Resident #9 Resident #9 was admitted on 5/12/09 with diagnoses including Hip Dislocation, right ankle fracture post motor vehicle accident. On 5/19/09 in the morning, the charge nurse (Employee #14) and the surveyor entered Resident #9's room. Resident #9 indicated that on Sunday, 5/17/09, she was wheeled back to her room by a staff member who was rude and provided improper care. Employee #14 was not aware of the incident. The resident alleged her injured foot kept hitting the side of the bed, when she was wheeled to the side of her bed by the alleged staff member. The resident indicated the staff member did not bother to pull the sheets down before "dumping" her on the bed. The resident thought the staff member's care was "rough." The resident indicated she told a female staff member the same day about the incident because she was upset by the way she was treated. Employee #10, who was in the room while the surveyor was interviewing Resident #9, indicated she was the staff member the resident informed on Sunday. Employee #10 indicated she informed the weekend charge nurse, Employee #7, on 5/17/09 in the afternoon, concerning the issue Resident #9 told her. On 5/20/09 in the afternoon, the Director of Nursing Services (DNS) confirmed the incident that occurred with Resident #9 on 5/17/09 was not properly reported to the abuse coordinator. Note: The investigation was initiated on 5/19/09, and the alleged employee was suspended on 5/19/09.	F 226		

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F 226	Continued From page 2 The DNS indicated the alleged employee worked on Monday, the day after the incident, due to the abuse coordinator not being informed of the incident. The DNS indicated the incident should have been reported immediately on Sunday and the abuse coordinator and the DNS should have been contacted. The initial investigation should have been initiated and the alleged employee suspended on 5/17/09. On 5/20/09 in the afternoon, Employee #10 indicated she did not inform Employee #7 that Resident #9 may have been treated inappropriately by another staff member. Employee #10 indicated she informed Employee #7 that Resident #9 wanted to talk with her. On 5/22/09 in the morning, a telephone interview was conducted with Employee #7. Employee #7 indicated she did not recall Employee #10 informing her concerning Resident #9's issues regarding improper patient care.	F 226		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 12211 Based on observation, interview, record review,	F 309		6/17/09

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and policy review, the facility failed to ensure the necessary care and services for 3 of 15 sampled residents (#8, #2, #13) and 1 unsampled resident (#16).

Findings include:

Resident #8

Resident #8 was a 74 year old female admitted 4/20/09 with diagnoses including Pneumonia Organism, Cardiomyopathy, Coronary Artery Disease, History of Myocardial Infarction and Stenting, Deep Vein Thrombosis, History of Rheumatoid Arthritis, Hypertension, Depression, Dyslipidemia, and Hypotension.

Resident #8's Admission Orders Record form dated 4/20/09 revealed Lasix 20 mg (milligrams), a diuretic, was ordered to be given orally everyday. There was no documented evidence a potassium supplement was also ordered.

Lab results revealed the following:

- Resident #8's potassium level on 4/22/09 was 4.2 MMOL/L (millimoles per Liter). Reference range of 3.6 - 5.6 MMOL/L.

- Resident #8's potassium level on 4/29/09 decreased to 3.5 MMOL/L, below the normal reference range of 3.6 - 5.6 MMOL/L. There was no documented evidence, Lasix was decreased or discontinued, a potassium supplement was ordered, or potassium levels were rechecked following the 4/29/09 results.

Resident #8's Resident Progress Notes dated 5/8/09 at 1900 (7:00 PM) revealed the physician

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was notified due to the resident complaining of loose stools.

The Physician's Telephone Orders dated 5/8/09 at 1930 (7:30 PM) revealed the physician ordered stool samples for C-diff (Clostridium Difficile infection).

On 5/19/09 in the afternoon interview, the physician (the facility's Medical Director) was asked when the resident's potassium level would be re-evaluated due to the resident's heart condition, continued use of the diuretic Lasix, no potassium supplement being taken, and decreasing potassium level. The physician indicated if the resident was experiencing loose stools then he would have considered obtaining another potassium level. The physician indicated he would have ordered a potassium level for Resident #8 on 5/19/09 due to being informed of loose stools but due to the resident's low blood pressure and diarrhea the resident was transferred to the hospital. With continued interview, if the resident had loose stools on 5/8/09, 5/9/09, or 5/10/09, a potassium level would have been obtained, the physician responded "Yes".

Resident #8 was transferred to Spring Valley Medical Center Emergency Room on 5/19/09. (The facility's Transfer and Referral Record 5/19/09 indicated: Vitals: Temperature: 96.6; Pulse=84; Respirations=18; Blood Pressure=81/40.) The Emergency Room record indicated that Resident #8 was admitted to the Hospital 5/19/09 at 1335 (1:35 PM). Initial Assessment: Blood Pressure=100/60; Pulse=84. Chief Complaint: "Pt (patient) being treated for pneumonia. Has had numerous loose stools... "

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F 309	Continued From page 5 The History and Physical Examination (5/20/09 11:47 PM) stated, "HISTORY OF PRESENT ILLNESS: The patient is a 74 year old female with past medical history of coronary artery disease, hypertension, dyslipidemia, rheumatoid arthritis who presented from Torrey Pines Care Center with history of diarrhea. The patient reports diarrhea increased over the past several days...REVIEW OF SYSTEMS: The patient denies any headaches, vision changes, or hearing changes. No chest pain, no palpitations, no shortness of breath, no cough. Reports generalized weakness. Reports intermittent nausea, but no vomiting. Reports having diarrhea over the past several weeks, worse over the past several days..." The Emergency Room record indicated that Resident #8 was admitted to the Hospital 5/19/09 at 1335 (1:35 PM). The hospital laboratory results indicated labs collected on 5/19/09 at 14:45 (2:45 PM) had a potassium level of 3.0 (indicating a low potassium level). The hospital Physician Orders form dated 5/19/09, revealed Resident #8's diagnoses were Diarrhea, Hypokalemia (low potassium), Thrombocytopenia, and Thrush. Intravenous fluids were ordered with added 20 Meq (milliequivalents) of potassium at 125 cc (cubic centimeters) an hour. Additional intravenous potassium was ordered 5 Meq an hour for a total of 40 Meq. Additional orders requested to start on 5/20/09, K-Dur (Potassium supplement) 20 Meq orally every 24 hours and to start on 5/21/09 Lasix 20 mg orally every 24 hours.	F 309		

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F 309	Continued From page 6 On 5/22/09 at 11:15 AM, the DNS (Director of Nursing Services) indicated that the facility's policy regarding reporting critical lab results is that all abnormal labs are reported to the physician and to the resident's family, and documented on the Resident's Nursing Notes that all parties were notified. The DNS indicated that any lab results out of range would be considered abnormal. Upon specific questioning regarding whether the DNS would be concerned about potassium levels below the reference range of 3.5, the DNS responded, "Normal is 3.6-5.0; it's only one decimal." The DNS further indicated she would contact the physician if she were to become aware that lab results had not been completed in more than 21 days. The DNS stated, "Our policy is to notify the doctor and he tells us what to do. We follow his directive." Upon further interview regarding what DNS would do if she did not agree with the physician, the DNS indicated she would go over his head and ask the corporate medical director to review the abnormal lab results. On 5/22/09 at 10:15 AM, the 100 North Charge Nurse (Employee #13) and the DNS (Director of Nursing Services) stated that Resident #8's overall skin condition was "fine." The Charge Nurse initially indicated that she was not aware of reddened skin and/or diarrhea until the morning of 5/19/09. However, the Charge Nurse later indicated that she was told by a CNA (Certified Nursing Assistant) on the evening of 5/18/09 that Resident #8 began having diarrhea 5/18/09 in the evening. On 5/22/09 at approximately 11:00 AM, the CNA (Employee #12) indicated she noticed on Sunday, 5/17/09 that Resident #8 had a reddened area on	F 309		

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the groin, applied A&D Ointment, and informed the charge nurse.

There was no documented evidence of a physician's order for the application of the A&D Ointment. There was no documentation contained in the Nurse's Notes of the reddened area on the groin and buttocks.

Policy Review Reference

The facility's policy regarding critical lab results ("Communicating Diagnostic Results," dated 5/28/08) stated as follows:

"Rationale: Diagnostic tests (e.g., laboratory, radiological, etc.) are performed upon a physician's order to assist the physician in determining the best treatment options for the resident. Test values that would result in serious adverse consequences for the resident are considered "critical".
Procedure: Guidelines:
1. Define a set of "high alert" results that get special precedence when communicating lab results that are critical. For example:
a. High Alert - requires stat page, immediate clinical decision required. Those values/interpretations that indicate the resident is in imminent danger of death, significant morbidity, or serious adverse consequences unless treatment is initiated immediately. These values/interpretations require immediate (within 1 hour) interruptive notification of the responsible (ordering or covering) physician who can initiate the appropriate clinical action for the resident.
b. Medium Alert - results are called; clinical decision required within hours. Those test

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values/interpretations that indicate significant abnormalities that warrant rapid, but not immediate, attention by the responsible clinician. These values do not represent a clinical emergency and do not warrant a stat page to the physician. These values require prompt clinical attention for the resident or for the resident's contacts to avoid serious adverse outcomes. Physicians should be notified of these values/interpretations within the shift (target 6 - 8 hours) and acknowledgement is required.
c. Low Alert - results can be sent passively; clinical decision required within days. Those test values/interpretations that indicate significant abnormalities that may threaten life or, cause significant morbidity, complications, or serious adverse consequences unless diagnosis and treatment is initiated in a timely and reliable manner. There is no immediate threat to life. These values/interpretations are targeted at diseases that merit timely detection and evaluation and for which a corrective action can be taken...
2. Define appropriate notification, time parameters for communicating critical test results according to urgency (e.g., within 1 hour, within the shift (target 6 - 8 hours), within 72 hours). For medium alert categories of critical lab results, the guiding principles for decision-making are:
*Maximize efficiencies of workflow issues
*Avoid unnecessary call late at night
*Synchronize calls with other existing systems, e.g., change of shifts, etc.
3. Develop a consistent standardized communication technique with the laboratory, physician, and nursing center to identify (flag) critical test values/interpretations. Licensed nurses, physician/healthcare professionals, and Lab staff should have the same understanding as

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F 309	Continued From page 9 follows: a. The definition of "high alert" categories b. Steps to take when escalation is necessary c. Use of "read back" techniques in the process of acknowledging receipt of lab results d. Time parameters and procedures for notification for all categories of lab results e. Documentation requirements f. Quality improvement monitoring plan g. Plan for annual review and validations. 4. Identify normal parameters for residents with chronic conditions (e.g., Diabetes or chronic anemia, etc.) that exhibit abnormal diagnostic results that may be considered as a "high alert" category in a healthy adult. 5. Document parameters in the resident's medical record (e.g., physician's orders, medication administration record, care plan, etc.) 6. Establish an explicit notification system for critical labs. An example for high alert critical labs may include: a. Notify the physician (MD #1) that ordered the lab. b. If no response after 15 minutes, call MD #1 again. c. If no response after 30 minutes, escalate to the alternate physician/on call (MD #2) (e.g., On call physician/secondary physician. d. If no response after 45 minutes, call MD #2 again. e. After 60 minutes, activate "fail-safe" plan; notify the Medical Director. (An example of a more accelerated follow-up would be 3 calls within first 10 minutes.) 7. Create tracking systems to assure timely and reliable communication of test results. 8. Develop special procedures for situations where delays typically occur: a. After discharge;	F 309		

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b. Ambulatory (across border);
c. Late arriving;
d. Other predictable relevant situations (shift changes, after-hours notifications, etc.);
e. The responsibility for tracking and follow-up on positive findings lies with the individual physician practice;
f. Design reliable follow-up systems for high-risk situations, e.g., certified letters with return receipt requested;
g. Explore the possibility that the laboratory, cardiology, and radiology would monitor the receipt (acknowledgement) and document handoff of the findings.
9. Develop strategies to assist licensed nursed (sic) in assessing when and how to notify residents, especially in cases when resident is no longer at the center.
10. Provide orientation and ongoing education on procedures for communicating test results/critical test results to licensed nurses and physicians.
Notifying the Physician of Lab Results
11. Notify attending physician and/or ordering physician (if different from attending) of lab results. Notification of physician should include at least:
a. Name and credentials of person notifying physician of lab results
b. Test name
c. Test value/interpretation
d. Date and time.
e. Pertinent Resident information (e.g., allergies, acute signs and symptoms, diagnoses, etc.)
(High Alert/Urgent/Critical values/results should be called immediately unless the physician has established normal parameters. The physician's response to a page is necessary. Results should not left with an answering service, receptionist, etc.)

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F 309	Continued From page 11 12. Follow the protocol in step 3, if physician fails to respond. 13. Ensure acknowledgement of receipt of test results by the physician or healthcare professional for test values/interpretations within the time frames for each category of test results (high, medium, low). (Examples of unacceptable acknowledgement systems include answering machines, all e-mails including those with read-receipt.) 14. Document date, physician notified, how notified (e.g., fax, telephone, etc.) on the diagnostic results (e.g., lab results, x-ray, etc.). 15. Document the results and the details of notification and the physician's response in the resident's medical record. 16. Notify the resident/responsible party, as appropriate. 17. Communicate laboratory results at change-of-shift and make an entry on the change of shift report to indicate that resident has lab results for any follow-up necessary. 18. Monthly, obtain a report from RCS to identify residents prescribed that have critical lab test physician orders. 1. Identify 10 critical tests ordered by physicians at the center. 1) Determine the acceptable length of time for: a. Obtaining the laboratory specimens and communicating pick-up to lab; b. Receiving the results of the lab tests; and c. Communicating the test results to the ordering physician. 2) Gather and review data on lab results that have occurred in the last month (e.g., logs, or audit tools, etc.) c. Determine: 1) Timeliness of obtaining the specimen after the physician has ordered the lab test.	F 309		

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F 309	Continued From page 12 2) Timeliness of lab communicating results of the test to the nursing staff. 3) Timeliness of nursing staff communicating results of the test to the physician and obtaining physician response. 19. Develop an action plan for any issues identified. 20. Consult with laboratory for measures the lab can implement to assist in timely communication of lab results (critical or otherwise). 21. Evaluate the action plan for effectiveness in resolving issues, update as necessary. Documentation Guidelines 12. Document in resident's medical record: a. Type of test obtained b. Reason for test (e.g., symptoms exhibited) c. Physician/other healthcare profession notification and order for test d. Family notification of test, as applicable e. Date and time of test received f. Physician and/or other healthcare professional response and new orders, if applicable. 2. Document in the employee education file, education regarding the process for diagnostic testing including notification of physician. 3. Document education of physician's and other healthcare professionals regarding center's process for obtaining diagnostic tests, notification of results, physician's/other healthcare professional's responsibility for following-up on diagnostics. 4. Document performance improvement reviews in the Performance Improvement Committee's minutes. 5. Document action plan to improve process and/or correct any issues regarding obtaining, receiving results and notification of physicians/other healthcare professionals and residents/family/responsible party.	F 309		

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6. Document implementation of action plan and evaluate for effectiveness at intervals. Update action plan as needed."
Surveyor: 13766

Resident #2

During the morning medication pass on 5/20/09, Employee #8 administered a 50 milligram (mg) tablet of Sertraline (generic Zoloft) to Resident #2 via gastrostomy tube (GT).

A Physician's Order dated 2/16/09, for Resident #2 documented, "Zoloft 75 mg 1 tablet via GT QAM (every morning)."
Surveyor: 22489

Resident #16

Resident #16 was admitted 5/17/09, with diagnoses including Atrial Fibrillation, Depression, Hypertension, Diabetes, Status Post Cardiac Catheterization.

On 5/20/09 in the morning, Employee #15 was administrating medications to Resident #16 and indicated Resident #16's heart rate was 57. Employee #15 administered Diltiazem 240 mg (milligrams) to Resident #16 and did not administer the resident's Digoxin tablet due to the heart rate being below 60 beats per minute.

Resident #16's Admission Orders Record form dated 5/18/09 documented:

-"...Diltiazem 240 mg 1 tab (tablet) QD (every day) Hold for HR (heart rate) <60 (less than 60..."

On 5/20/09 in the morning, Employee #15

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	295045	A. BUILDING _____ B. WING _____	05/22/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TORREY PINES CARE CENTER	1701 S. TORREY PINES DRIVE LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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confirmed that she should not have administered resident #16's Diltiazem tablet due to the low heart rate.

Resident #13

Resident #13 was admitted on 12/24/08, with diagnoses including Chronic Obstructive Pulmonary Disease, Debility, Chronic Pain Syndrome, and Hypertension.

On 5/20/09 in the morning, Resident #13 was administered three antibiotics:

-Rifampin 600 mg orally
-Myambutol 1800 mg orally
-Zithromax 600 mg orally

On 5/22/09 in the afternoon, the facility driver/scheduler indicated Resident #13 refused to go to his infectious disease appointment on the first week of April.

Resident #13's Physician's Telephone Orders form dated 4/7/09 indicated to notify the infectious disease physician to determine when to stop the antibiotic.

On 5/22/09 in the afternoon, the infection control nurse was not aware that Resident #13 refused his appointment to see the infectious disease physician in April. The Infectious disease nurse could not find any documentation on when to discontinue Resident #13's antibiotics. The infectious disease nurse indicated she needed to contact the infectious disease physician to determine when to discontinue the antibiotics and explain to the resident the consequences of

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F 309	Continued From page 15 missing appointments with the infectious disease physician.	F 309		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 13766 Based on observation and interview, the facility failed to ensure one resident remained free of hazards due to lack of proper foot wear (#11). Findings include: Resident #11 Resident #11 was a 78 year old male admitted 4/10/09 with diagnoses including Hyperlipidemia, Chronic Kidney Disease, Hypertension, Atherosclerosis of Aorta, and Old Occipital Lobe CVA (Cerebral Vascular Accident). During the initial tour on 5/19/09, Resident #11 was observed self propelling in his wheelchair wearing slipper socks. The resident's wheelchair was not equipped with foot rests. In the afternoon on 5/19/09, Resident #11 indicated the therapy department did not want him to use foot rests on his wheelchair. He	F 323		6/17/09

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indicated, "They said something about me not using my legs would make the muscles go weak, and I'm ok with that." The resident indicated he would like to have shoes instead of propelling around in socks. He indicated he had shoes, however he needed a new pair because they were lost and he had not seen them since his admission in April. Resident #11 indicated he told the Social Worker and that the Social Worker was working on getting him a pair. He indicated it was some time ago when he asked.

On 5/21/09 in the morning, the Social Worker indicated he would look into getting shoes for Resident #11. He indicated he did not remember if the resident came in with shoes. He indicated many of the residents come from the hospital and they may not be wearing shoes when admitted.

On 5/20/09 in the morning, Resident #11 was propelling in his wheelchair by the therapy room. A female resident bumped into Resident #11 with her wheelchair and nearly ran over his feet. Resident #11 backed up his wheelchair and the female resident moved forward and again nearly ran over Resident #11's feet. Resident #11 was wearing slipper socks during the incident. Resident #11 indicated that the female resident almost ran over his feet twice.

On 5/22/09 in the afternoon, Employee #16 indicated that Resident #11 was able to ambulate with a walker and he chose to use the wheelchair. She indicated Resident #11 did not have foot rests on his wheelchair to encourage him to use the muscles in his legs. She indicated Resident #11 could have foot rests if he wanted them. Employee #16 indicated Resident #11 was able to wear shoes if he want to wear them. She

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F 323	Continued From page 17 indicated therapy did not provide shoes and that would be a Social Service issue. On 5/22/09, the Lead Physical Therapist indicated Resident #11 was able to ambulate 200 feet with a front wheel walker, however the resident liked to self propel in his wheelchair. He indicated shoes are always recommended, however therapy only supplied residents with slipper socks.	F 323		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431		6/17/09

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F 431	Continued From page 18 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Surveyor: 13766 Based on observation and interview, the facility failed to ensure one box of medication was labeled with the correct expiration date. Findings include: During an inspection of the Northwest medication cart on 5/20/09, a box of Loratadine 10 milligrams containing 28 tablets had an expiration date of 5/18/10. The individual blister packets stored inside the box had expiration dated of 5/18/09. On 5/20/09, the Medication Nurse removed the box from the medication cart and indicated she was going to show them to the Director of Nursing Services. On 5/20/09, the Director of Nursing Services indicated the box was returned to the pharmacy who had mis-labeled the tablet's expiration date.	F 431		